LEGACY HEART CARE

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize, Legacy Heart Care of Charlotte, LLC, to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Information to be used or disclosed:

☐ Progress Notes	☐ Medication Sheet
☐ EKG	☐ Echocardiogram
☐ Stress Test	☐ Cardiac Catheterization
☐ Operative Reports	☐ History & Physical
☐ Admission Summary	☐ Discharge Summary
☐ Laboratory Tests	☐ Other _____

Persons Authorized to use or disclose information:

☐ Cardiologist: _____

☐ Primary Care Physician: _____

☐ Other: _____

Persons to whom information may be disclosed:

Legacy Heart Care of Charlotte, LLC
300 Billingsley Road, Ste 101 Charlotte, NC 28211
(704) 334-1401 Phone (704) 334-1471 Fax

Expiration Date of Authorization

This authorization is valid for one year after the date you sign it unless you enter a different date or expiration here:_____, unless revoked or terminated by the patient or their personal representatives.

Right to Terminate or Revoke Authorization

To revoke or terminate this authorization submit a written revocation to Legacy Heart Care of Charlotte, LLC.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Birth Date

LEGACY HEART CARE

Medical Information Release Form

(HIPAA Release Form)

Name: _____

Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until **terminated by me in writing**.

Messages

Please call: [ ] my home _____

[ ] my work _____

[ ] my cell _____

If unable to reach me:

[ ] you can leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

LEGACY HEART CARE

Appointment of Representative

Provider Name: Legacy Heart Care of Charlotte, LLC.

300 Billingsley Road, Ste 101 Charlotte, NC 28211

Provider Tax ID: 47-5454447

Provider NPI: 1467510663

Appointment of Representative: I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated above.

Patient Name: _____ Member ID: _____

Address: _____ City, State, Zip: _____

Phone: _____

_____ _____

Signature of Party Seeking Representation (patient) Date

Acceptance of Representative: I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative and that I recognize that any fee may be subject to review and approval by the Secretary.

_____ _____

Signature of Appointed Representative Date

_____ _____

Printed Name Title

_____ _____

Phone Fax

LEGACY HEART CARE

Notice of Privacy Practices Acknowledgement

Patient Name:_____ Date of Birth: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how our health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations.

☐ I have received the Notice of Privacy Practices

_____ _____
Patient's (or Legal Representative) Signature Date

_____
Relationship of Legal Representative

Office Use Only

To be completed only if acknowledgement is not signed.

1. Does Patient have a copy of the Privacy Notice? ❑ Yes or ❑ No

2. If answered "No" above, please explain why the patient did not sign the acknowledgement form and Legacy Heart Care of Charlotte, LLC efforts in trying to obtain the patients signature:

   - ❑ Individual or Personal Representative chose not to sign
   - ❑ Individual or Personal Representative did not respond after more than **one** attempt
   - ❑ Patient Unable to Comprehend
   - ❑ Patient Communication Barrier
   - ❑ Other:_____

Completed by:

_____ _____
Legacy Heart Care of Charlotte, LLC Representative Date

LEGACY
HEART CARE

CONNECT WITH US ONLINE

through any of your favorite
social media channels

LEGACY HEART CARE — legacyheartcare.com

facebook.com/legacyheartcare

LinkedIn — linkedin.com
Legacy Heart Care

Pinterest — pinterest.com/legacyheartcare

twitter.com/legacyheartcare

plus.google.com
Legacy Heart Care

YouTube — youtube.com/legacyheartcare

LEGACY HEART CARE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice takes effect on July 1, 2017, and remains in effect until we replace it.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share your medical information. It also describes your rights and certain duties we have regarding the use and disclosure of medical information. We want you to understand what is in your medical information and how this information may be shared with others so that you can make informed decisions when you authorize the release of your medical records.

UNDERSTANDING YOUR MEDICAL RECORD

Each time you visit Legacy Heart Care of Charlotte, LLC a record of your visit is made. Typically, this record contains your symptoms, along with the doctor's/nurse's examination, diagnosis, and plan of treatment. Any tests that may be done will be included along with test results. This information is often referred to as your medical record or your protected health information. This information is utilized in a variety of ways:

1. It is the basis for planning your care and treatment.
2. It is a means of communication among the many health professionals who contribute to your care.
3. It is a legal document describing the care you received.
4. It is the means by which you or a third-party can verify that the services billed were actually provided.
5. It is a tool that may be used to train other health professionals.
6. It is a source of data that may be used for medical research.
7. It is a source of information for public health officials who oversee the delivery of health care in the United States.
8. It is a source of data that may be used to plan for the growth of this practice.
9. It is a source of information that may be used to assess the quality of our work and improve the care that we provide to patients.

OUR LEGAL DUTY

The law requires us to:

1. Keep your medical information private.
2. Give you this notice about our legal duties and the steps we take to insure the privacy of your medical information.
3. Follow the terms of the notice that is currently in effect.

We have the right to:

1. Change the procedures in this notice at any time, provided the changes are permitted by law. Should we do so, we will mail you a revised notice.
2. Make the changes in the notice effective for all medical information that we keep, including information previously created or received before the effective date.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

We will not use or share your health information without your permission, except as described below.

Treatment: We will use your protected health information to carry out treatment of your diagnosed problems.

For example, information that is written by the Nurse may be used by the Doctor to determine a plan of treatment. If tests are needed to determine the correct diagnosis, information may be shared with a testing facility, a testing technician, or another doctor for the purpose of further evaluation as well as billing. If prescription medication is needed, information will be shared with the pharmacy of your choice. If medical equipment is needed, information may be shared with the durable medical equipment dealer of your choice. If more specialized treatment is needed, records regarding your examinations and treatment will be forwarded to the specialist, nursing home, or other health care facility to assist in further diagnosis, treatment, and billing.

Payment: We will use your protected health information in order to receive payment for our services.

For example, in order to bill Medicare or any other insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

Health Care Operations: We will use your protected health information to complete routine operations at this medical practice.

For example, your protected health information may be used or compared to other patients with similar diagnoses in an effort to continually improve the quality and effectiveness of the service we provide. In addition, because this is a small office every employee has been cross-trained to complete multiple tasks outside of their specific job duties so that the office functions smoothly even if someone is out sick. As a result, every employee (the Doctor, Nurse, Receptionist, and Office Manager) may have access to your protected health information at one time or another for the purpose of carrying out treatment, payment, or health care operations.

Business Associate: We may utilize contracts with business associates for a variety of services necessary for maintaining a medical practice. In the process of carrying out their contracted duties, these associates may have access to your protected health information.

For example, all medical information is stored in a computer database, and our computer software is supported by a software support company, which has dial in access for specific and contracted purposes. In addition, this office is routinely inspected and audited by companies such as insurance providers, the local fire department, and OSHA. We also utilize accountants, consultants, and attorneys. For your protection, each company/person who has access to any part of your protected health information will sign a Business Partner Agreement that details the confidential nature of our records and their individual responsibility to maintain confidentiality.

Appointment Reminders: We may use or disclose your PHI to contact you to remind you of an upcoming appointment.

For example, Legacy Heart Care uses an automated calling and text system to remind you and confirm your upcoming appointment with us. Text reminders are sent out to remind patients of their upcoming orientation, MD visit (if applicable), and new start for your EECP treatment. You can opt out of this system at any time. All patients who opt out will receive reminder calls from a Legacy staff member.

Notification: We may utilize telephone reminders for appointments with our office as well as appointments that are scheduled with consulting providers. We may also utilize telephone contact to provide you with lab results and other test results. If we are unable to reach you or a family member at the numbers provided, we will leave a message on the answering machine or call the emergency contact number.

Communication with family: We will not disclose your protected health information to family members without your approval. If you have given your approval, health professionals will use their best judgment regarding what information is relevant to that person's involvement in treatment or in payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy to your protected health information.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may share health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may share your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may share with the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may share health information for law enforcement purposes as required by law or in response to a valid subpoena.

Reports: Federal law requires us to release your protected health information to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believed in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Schools: At your verbal request, we will release information to the identified school regarding the date and time of office visits for school absentee notice.

Employers: At your verbal request, we will release information to the identified employer regarding the date and time of office visits for work absentee notice, as well as work release status when physical limitations are required due to injury or illness.

For all other circumstances: Protected health information will not be disclosed without your signed consent, unless the law specifies that consent, authorization, or the opportunity to agree or object is *not* required.

YOUR RIGHTS

Although your medical record is the physical property of this medical practice, the information in your record belongs to you. As a result, you may exercise the following rights in regard to your information. If you wish to initiate any of the following actions, we request that you do so in writing on a form provided by this office. You may request a copy of the form from any employee. Once the form is completed, it should be submitted to the Office Manager.

You have the following rights:

1. You may look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We may charge a reasonable fee for this service and will provide the requested information within the timeframes established by law.

2. You may request a list of the times we shared your medical information. Please note that this accounting will not apply to disclosures made prior to the effective date of this new procedure, or to any of the following types of disclosures:
    a. Disclosures made for the purpose of treatment, payment or health care operations;
    b. Disclosures made to you, your legal representative, or any other individual involved with your care;
    c. Disclosures to correctional institutions or law enforcement officials;
    d. And disclosures for national security purposes.

3. You may request that we place additional restrictions on the use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement. This will not apply to information used or disclosed prior to the agreement date.

4. You may request that we communicate with you about your medical treatment or progress by a different means or at a different location.

5. If you believe that the medical information created by this office is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. If we agree with your request, we will make reasonable efforts to share this information with those that you request, and include the changes in any future disclosure of information. If we deny your request we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information in your medical records.

6. You have the right to obtain a copy of our Notice of Information Sharing Practices upon request.

7. If you agree to this notice and decide at a later time to revoke your authorization, you may do so. We will abide by your decision except to the extent that action has already been taken.

8. You may file a complaint with us or the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us to our HIPAA compliance officer see the information at the end of this notice. Complaints must be submitted within 180 days from when you knew of the suspected violation. **There will be no retaliation against you for filing a complaint.**

QUESTIONS OR COMPLAINTS

If you have questions and would like additional information, please contact:

Dorthy Lukens
HIPAA Compliance Officer
2500 West Freeway, Suite 200
Fort Worth, TX 76102
817-423-4400

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue
S.W. Washington, D.C. 20201
202-619-0257
877-696-6775

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by this office. You may request the form from any staff member and the form must be submitted to the contact person listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. **There will be no retaliation for filing a complaint**.

LEGACY HEART CARE

Attendance and Compliance Policy

The Purpose of this policy is to ensure adequate compliance and to provide optimal clinical outcomes. It is our goal at Legacy Heart Care of Charlotte, LLC. to achieve clinical excellence above the minimum standard of care while providing a pleasant experience.

Legacy Heart Care of Charlotte, LLC fully understands that at times it might be difficult to make your pre-arranged treatment time. We will gladly reschedule your treatment time to any available opening in the schedule to accommodate your personal needs. It is our firm belief that achieving an attendance rate of 80% is not only reasonable but is vital to promote adequate clinical progress. In the event an individual's attendance rate drops below the 80%, and there are patients waiting for treatment due to a full treatment schedule, that individual may be subject to a treatment stoppage so that others may begin treatment without an unnecessary delay in care. This policy will be reviewed on a case by case basis for its appropriate implementation and to consider each individual circumstance affecting their attendance.

Signing this document certifies that you understand the clinical efficacy of Enhanced External Counterpulsation (EECP) is driven by patient attendance, and Legacy Heart Care of San Antonio's view on compliance policy; and agree to its enforcement in the event it becomes appropriate. If you have any questions or concerns, please do not hesitate to speak with a Legacy Representative.

_____	_____
Printed Patient Name	Date of Birth
_____	_____
Signature Patient	Date
_____	_____
Legacy Heart Care of Charlotte, LLC Representative	Date